MUTUAL OF OMAHA INSURANCE COMPANY

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BENEFIT PLANS A, B, C, D, F, G, AND M

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans "A and B" and either "C or F." Some plans may not be available in your state. See Outlines of Coverage sections for details about ALL plans.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days in your lifetime after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First 3 pints of blood each year.

Hospice: Part A coinsurance.

Plan A	Plan B	Plan C	Plan D	Plan F F*	Plan G
Basic, including 100% Part B co-insurance	**Basic, including 100% Part B co-insurance**	**Basic, including 100% Part B co-insurance**	**Basic, including 100% Part B co-insurance**	**Basic, including 100% Part B co-insurance ***	**Basic, including 100% Part B co-insurance**
		Skilled Nursing Facility Co-insurance	**Skilled Nursing Facility Co-insurance**	**Skilled Nursing Facility Co-insurance**	**Skilled Nursing Facility Co-insurance**
	Part A Deductible	**Part A Deductible**	**Part A Deductible**	**Part A Deductible**	**Part A Deductible**
		Part B Deductible		**Part B Deductible**	
				Part B Excess (100%)	**Part B Excess (100%)**
		Foreign Travel Emer-gency	**Foreign Travel Emer-gency**	**Foreign Travel Emer-gency**	**Foreign Travel Emer-gency**

Plan K	Plan L	Plan M	Plan N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	**Basic, including 100% Part B co-insurance**	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	**Skilled Nursing Facility Co-insurance**	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	**50% Part A Deductible**	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $4,960; paid at 100% after limit reached	Out-of-pocket limit $2,480; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy/certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plans' separate foreign travel emergency deductible.

MONTHLY PREMIUMS
ZIP CODES: 128-139, 144-149

Attained Age	Policy Form MM20 Plan A	Policy Form MM21 Plan B	Policy Form MM22 Plan C	Policy Form MM23 Plan D	Policy Form MM24 Plan F	Policy Form MM25 Plan G	Policy Form MM30 Plan M
All Ages	**173.99**	**267.83**	**322.86**	**282.46**	**332.78**	**267.91**	**275.10**

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY PREMIUMS
ZIP CODES: 06390

Attained Age	Policy Form MM20 Plan A	Policy Form MM21 Plan B	Policy Form MM22 Plan C	Policy Form MM23 Plan D	Policy Form MM24 Plan F	Policy Form MM25 Plan G	Policy Form MM30 Plan M
All Ages	**179.99**	**277.06**	**333.99**	**292.20**	**344.25**	**277.15**	**284.58**

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY PREMIUMS

ZIP CODES: 10910, 10912, 10914-919, 10921-922, 10924-926, 10928, 10930, 10932-933, 10940-941, 10943, 10949-950, 10953, 10958-959, 10963, 10969, 10973, 10975, 10979, 10981, 10985, 10987-988, 10990, 10992, 10996-998, 120-127, 140-143

Attained Age	Policy Form MM20 Plan A	Policy Form MM21 Plan B	Policy Form MM22 Plan C	Policy Form MM23 Plan D	Policy Form MM24 Plan F	Policy Form MM25 Plan G	Policy Form MM30 Plan M
All Ages	**183.99**	**283.22**	**341.41**	**298.69**	**351.90**	**283.31**	**290.91**

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY PREMIUMS

ZIP CODES: 005, 100-108, 10901, 10911, 10913, 10920, 10923, 10927, 10931, 10951-952, 10954, 10956, 10960, 10962, 10964-965, 10968, 10970, 10974, 10976-977, 10980, 10982-984, 10986, 10989, 10993-995, 110 - 119

Attained Age	Policy Form MM20 Plan A	Policy Form MM21 Plan B	Policy Form MM22 Plan C	Policy Form MM23 Plan D	Policy Form MM24 Plan F	Policy Form MM25 Plan G	Policy Form MM30 Plan M
All Ages	**231.99**	**357.10**	**430.48**	**376.61**	**443.70**	**357.22**	**366.79**

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

Premium Information
We, Mutual of Omaha, can only raise your premium if we raise the premium for all the policies like yours in the same classification in this state.

Disclosures
Use this outline to compare benefits and premiums among policies.

Read Your Policy Very Carefully
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and the Mutual of Omaha Insurance Company.

Right to Return Policy
If you find that you are not satisfied with your policy, you may return it to Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice
The policy may not fully cover all of your medical costs. Neither Mutual of Omaha nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete Answers Are Very Important
Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLANS A AND B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A Pays	You Pay	Plan B Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies					
First 60 days	All but $1,288	$0	$1,288 (Part A Deductible)	$1,288 (Part A Deductible)	$0
61st through 90th day	All but $322 a day	$322 a day	$0	$322 a day	$0
91st day and after:					
While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0	$644 a day	$0
Once lifetime reserve days are used:					
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	$0	$0	$0	$0
21st through 100th day	All but $161.00 a day	$0	Up to $161.00 a day	$0	Up to $161.00 a day
101st day and after	$0	$0	All costs	$0	All costs
BLOOD					
First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

PLANS A AND B
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $166 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay	Plan B Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $166 of Medicare Approved Amounts*	$0	$0	$166 (Part B Deductible)	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $166 of Medicare Approved Amounts*	$0	$0	$166 (Part B Deductible)	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment First $166 of Medicare Approved Amounts*	$0	$0	$166 (Part B Deductible)	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0

PLANS C AND D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan C Pays	You Pay	Plan D Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0	$1,288 (Part A Deductible)	$0
61st through 90th day	All but $322 a day	$322 a day	$0	$322 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0	$644 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days	All approved amounts	$0	$0	$0	$0
21st through 100th day	All but $161.00 a day	Up to $161.00 a day	$0	Up to $161.00 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0	Medicare copayment/coinsurance	$0

PLANS C AND D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $166 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan C Pays	You Pay	Plan D Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $166 of Medicare Approved Amounts*	$0	$166 (Part B Deductible)	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $166 of Medicare Approved Amounts*	$0	$166 (Part B Deductible)	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment First $166 of Medicare Approved Amounts*	$0	$166 (Part B Deductible)	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0

PLANS C AND D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan C Pays	You Pay	Plan D Pays	You Pay
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA					
First $250 each calendar year	$0	$0	$250	$0	$250
Remainder of charges	$0	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit

PLANS F AND G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0	$1,288 (Part A Deductible)	$0
61st through 90th day	All but $322 a day	$322 a day	$0	$322 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0	$644 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days	All approved amounts	$0	$0	$0	$0
21st through 100th day	All but $161.00 a day	Up to $161.00 a day	$0	Up to $161.00 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0	Medicare copayment/coinsurance	$0

PLANS F AND G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $166 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $166 of Medicare Approved Amounts*	$0	$166 (Part B Deductible)	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	100%	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $166 of Medicare Approved Amounts*	$0	$166 (Part B Deductible)	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment First $166 of Medicare Approved Amounts*	$0	$166 (Part B Deductible)	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0

PLANS F AND G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA					
First $250 each calendar year	$0	$0	$250	$0	$250
Remainder of charges	$0	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit

PLAN M

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan M Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$644 (50% of Part A Deductible)	$644 (50% of Part A deductible)
61st through 90th day	All but $322 a day	$322 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $161.00 a day	Up to $161.00 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment /coinsurance	$0

PLAN M
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $166 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan M Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $166 of Medicare Approved Amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $166 of Medicare Approved Amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

Services	Medicare Pays	Plan M Pays	You Pay
HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $166 of Medicare Approved Amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit